



FEB 5 2001

**Memorandum**

Date *Michael Mangano*  
From Michael F. Mangano  
Acting Inspector General

Subject Improper Fiscal Year 2000 Medicare Fee-for-Service Payments (A-17-00-02000)

To Michael McMullan  
Acting Principal Deputy Administrator  
Health Care Financing Administration

Attached, as you requested, is our final report on the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled \$11.9 billion, or about 6.8 percent of the \$173.6 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). As in past years, these improper payments could range from inadvertent mistakes to outright fraud and abuse.

Since we developed the first error rate for FY 1996, HCFA has closely monitored Medicare payments and has instituted appropriate corrective actions. The HCFA has also worked with provider groups to clarify reimbursement rules and to impress upon health care providers the importance of fully documenting services. Additional initiatives on the part of the Congress, HCFA, the Department of Justice, and the Office of Inspector General have focused resources on preventing, detecting, and eliminating fraud and abuse. All of these efforts, we believe, have contributed to reducing the improper payment rate by almost half from FY 1996 to 2000. However, continued vigilance is needed to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims. These problems have persisted for the past 5 years. Our recommendations address the need for HCFA to sustain its efforts in reducing improper payments.

We have incorporated HCFA's comments on the draft report where appropriate. We appreciate the cooperation and assistance provided by you and your staff.

If you have any questions, please contact me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**IMPROPER FISCAL YEAR 2000  
MEDICARE FEE-FOR-SERVICE  
PAYMENTS**



**Inspector General**

**FEBRUARY 2001**

**A-17-00-02000**



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This final report presents the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. The objective of this review was to estimate the extent of fee-for-service payments that did not comply with Medicare laws and regulations. This is the fifth year that the Office of Inspector General (OIG) has estimated these improper payments. As part of our analysis, we have profiled the last 5 years' results and identified specific trends where appropriate.

Our review of 5,234 claims valued at \$5.3 million disclosed that 1,125 did not comply with Medicare laws and regulations. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled \$11.9 billion, or about 6.8 percent of the \$173.6 billion in processed fee-for-service payments reported by the Health Care Financing Administration (HCFA). ***These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud.*** The overwhelming majority (92 percent) of the improper payments were detected through medical record reviews which we coordinated. When these claims were submitted for payment to Medicare contractors, they contained no visible errors.

This year's estimate of improper payments is the lowest estimate to date and about half the \$23.2 billion that we estimated for FY 1996. There is convincing evidence that this reduction is statistically significant. However, we cannot conclude that this year's estimate is statistically different from the estimates for FY 1999 (\$13.5 billion) or 1998 (\$12.6 billion). The decrease this year may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments.

We believe that since we developed the first error rate for FY 1996, HCFA has demonstrated continued vigilance in monitoring the error rate and developing appropriate corrective action plans. For example, HCFA has worked with provider groups, such as the American Medical Association and the American Hospital Association, to clarify reimbursement rules and to impress upon health care providers the importance of fully

documenting services. Such efforts have contributed to the large reduction in the improper payment rate. In addition, due to efforts by HCFA and the provider community, the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, since FY 1998, over 90 percent of Medicare fee-for-service payments have contained no errors. Lastly, fraud and abuse initiatives on the part of HCFA, the Congress, the Department of Justice (DOJ), and OIG have had a significant impact.

However, continued vigilance is needed to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims. These problems have persisted for the past 5 years.

## **BACKGROUND**

The Medicare program (Title XVIII of the Social Security Act) was established by the Social Security Amendments of 1965 to cover the health care needs of people aged 65 and over, the disabled, people with end stage renal disease, and certain others who elect to purchase Medicare coverage. In FY 2000, about 39.5 million beneficiaries were enrolled in the program, and HCFA incurred about \$214.6 billion nationwide in Medicare benefit payments. Fee-for-service payments accounted for about \$173.6 billion of this total.

Medicare consists of two programs, each with its own enrollment, coverage, and financing:

- Hospital insurance, also known as Medicare Part A, is usually provided automatically to people aged 65 and over and to most disabled people. It covers services rendered by participating hospitals (including prospective payment system (PPS) hospitals), skilled nursing facilities, home health agencies, and hospice providers.
- Supplementary medical insurance, also known as Medicare Part B, is available to nearly all people aged 65 and over and the disabled entitled to Part A. This optional insurance is subject to monthly premium payments by beneficiaries. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, designated therapy services, and some other services not covered by Medicare Part A.

The HCFA pays the following types of contractors to process fee-for-service claims:

- Fiscal intermediaries (FI) process Part A payments for hospitals, skilled nursing facilities (SNF), home health agencies (HHA), rural health clinics, hospices, end stage renal disease facilities, and other institutional providers.
- Carriers process Part B payments for physicians, clinical laboratories, free-standing ambulatory surgical centers, and other noninstitutional providers.

- Durable medical equipment regional carriers (DMERC) process claims from suppliers of durable medical equipment, prosthetics, orthotics, and other supplies under Medicare Part B except those for items incident to physician services in rural health clinics or included in payments to such providers as hospitals, SNFs, and HHAs.

To ensure the quality of care provided to Medicare beneficiaries, HCFA also contracts with peer review organizations (PRO) to conduct a wide variety of quality improvement programs. For example, PRO medical review personnel assess medical record documentation to determine whether the services rendered were medically necessary, appropriate, and met professionally recognized standards of care.

## AUDIT OBJECTIVE

Our primary objective was to determine whether Medicare fee-for-service benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations (CFR). Specifically, we determined whether services were:

- furnished by certified Medicare providers to eligible beneficiaries;
- reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and
- medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

## AUDIT SCOPE AND METHODOLOGY

**Statistical Selection Method.** To accomplish our objective, we used a multistage, stratified sample design. In the first stage, our sample frame consisted of 148 contractor quarters. Twelve contractor quarters were selected based on probability-proportional-to-size using Rao, Hartley, Cochran methodology. We used fourth quarter FY 1998 Medicare fee-for-service benefit payments and the first, second, and third quarters of FY 1999 as the selection weighting factors (size of each contractor quarter). The 12 contractor quarters included 10 contractors, of which 4 were FIs; 1 was a carrier; 3 were both FIs and carriers; 1 was a carrier and a DMERC; and 1 was an FI, a carrier, and a DMERC.

The second stage of our sample design consisted of a random sample of 50 beneficiaries from each of the 12 contractor quarters sorted into 4 strata by total payments for services. The random sample of 610 beneficiaries produced 5,234 claims valued at \$5.3 million for review.<sup>1</sup> To ensure the completeness of the claim data, we reconciled Medicare contractor claim data to the HCFA 1522 Monthly Financial Reports for the 12 contractor quarters selected. The HCFA used these reports in preparing the FY 2000 financial statements.

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<sup>1</sup> For one contractor quarter, the initial universe did not include all beneficiaries. Therefore, an additional random sample of 10 beneficiaries was selected for review.

The relative probability of selection for the contractor quarters and beneficiaries was incorporated into the overpayment estimate so that the estimate was not biased by a focus on the larger contractors and the beneficiaries with higher payments. The statistical software used to compute the estimate included the appropriate formulas for the relative probabilities of selection, which are referred to as "weights."

We used a variable appraisal program to estimate the dollar value of improper payments in the total population. The population represented \$173.6 billion in fee-for-service payments.

***Audit Procedures.*** We reviewed all claims processed for payment for each selected beneficiary during the 3-month period. We contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response from our initial letter, we made numerous followup contacts by letter and, in most instances, by telephone calls. At selected providers, we also made onsite visits to collect requested documentation.

Medical review staff from HCFA's Medicare contractors and PROs assessed the medical records to determine whether the services billed were reasonable, adequately documented, medically necessary, and coded in accordance with Medicare reimbursement rules and regulations. To make these determinations, the staff applied coverage guidelines, including the Medicare carrier and fiscal intermediary manuals. In the case of physician evaluation and management codes, the medical staff used the Current Procedural Terminology (CPT) Manual developed by the American Medical Association. We coordinated these medical reviews to ensure their consistency and accuracy.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on past improper billing practices, to determine whether:

- the contractor paid, recorded, and reported the claim correctly;
- the beneficiary and the provider met all Medicare eligibility requirements;
- the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare Secondary Payer); and
- all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Building on this methodology, in FY 1998, HCFA began developing a new Medicare contractor-specific error rate methodology called Comprehensive Error Rate Testing (CERT). CERT will establish for the first time baselines to measure each contractor's progress toward correctly processing and paying claims. The results will reflect the contractor's performance and will identify specific provider billing anomalies in the region. Contractors will then develop targeted corrective action plans to reduce payment errors through provider education, claims review, and

other activities, and HCFA will closely evaluate their rate of improvement. At HCFA's request, the contractor selected to administer the CERT program reviewed the errors that the Medicare contractors' medical reviewers found in our FY 2000 sample. Thus, the results of this year's review are based on two separate, independent medical reviews.

In addition, we reviewed HCFA's corrective action plan addressing recommendations cited in our previous years' reports. We made this review in accordance with generally accepted government auditing standards and in conjunction with the audit of HCFA's FY 2000 financial statements. The Chief Financial Officers Act of 1990 requires Federal agencies to improve systems of financial management, accounting, and internal controls to ensure that they issue reliable financial information. Also, the Government Management Reform Act of 1994 requires full-scope audits of the financial statements of Federal agencies, including the Department of Health and Human Services.

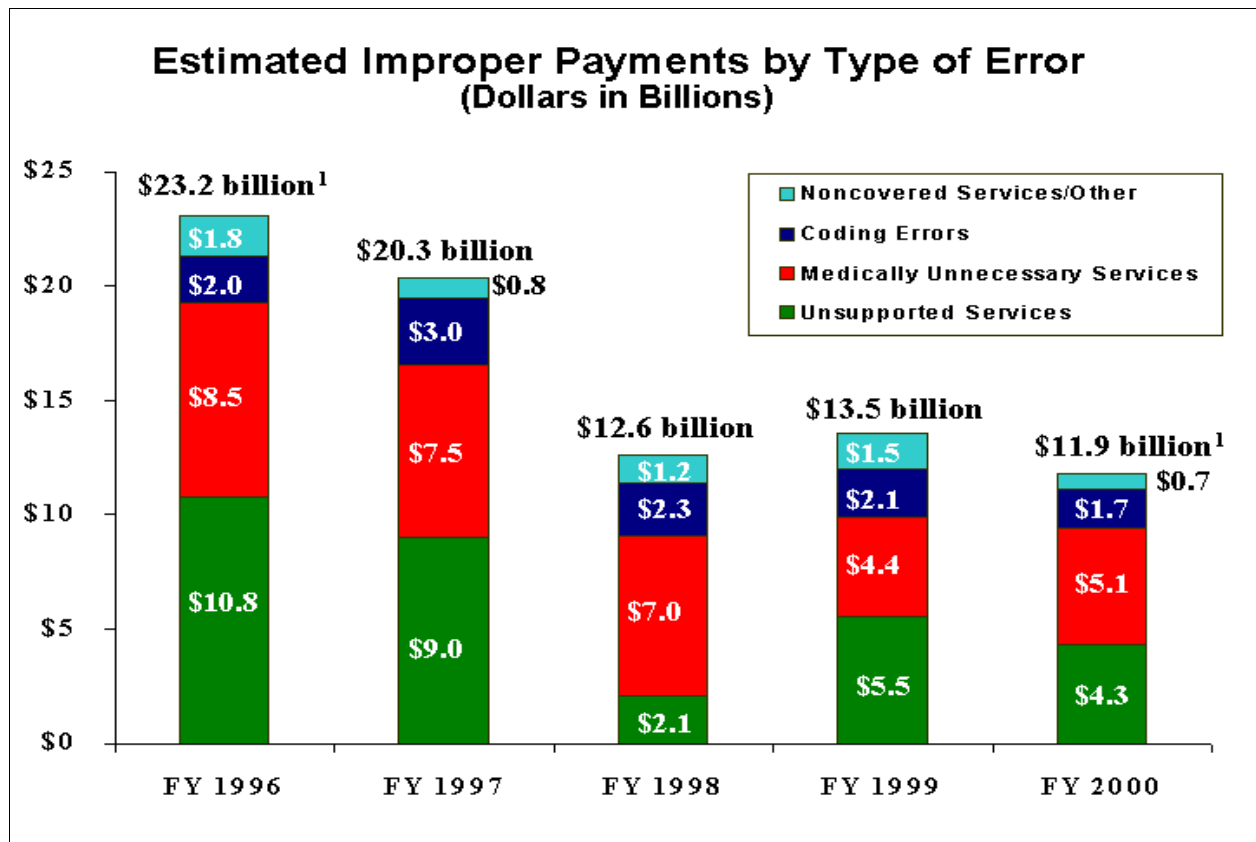
## **RESULTS OF REVIEW**

Through detailed medical and audit reviews of a statistical selection of 610 beneficiaries nationwide with 5,234 fee-for-service claims processed for payment during FY 2000, we found that 1,125 claims did not comply with Medicare laws and regulations. The contractors have disallowed and already recovered many of the overpayments identified in our sample, consistent with their normal claim adjudication process. Based on our statistical sample, the point estimate of improper Medicare benefit payments made during FY 2000 was \$11.9 billion, or about 6.8 percent of the \$173.6 billion in processed fee-for-service payments reported by HCFA. The estimated range of the improper payments at the 95 percent confidence level is \$7.5 billion to \$16.2 billion, or about 4 percent to 9 percent, respectively.

Our historical analysis indicates that HCFA has made sustained progress in reducing improper payments. For FY 1996, the first year that we developed an error rate, estimated improper payments totaled \$23.2 billion, or about 14 percent of the fee-for-service payments reported by HCFA. Thus, we have seen the estimate drop by \$11.3 billion, a reduction of almost 50 percent, in 5 years. This reduction, in our opinion, is attributable to HCFA's continuing corrective actions; efforts by health care providers to comply with Medicare reimbursement regulations; and fraud and abuse initiatives on the part of HCFA, the Congress, DOJ, and OIG.

As noted in the following chart, this year's estimate is the lowest to date. While there is convincing evidence that it is statistically different from the FY 1996 estimate, we cannot conclude that it is statistically different from the estimates for FYs 1999 and 1998. In this connection, the FY 2000 \$11.9 billion point estimate falls within the FY 1999 estimated range of improper payments at the 95 percent confidence level (\$9.1 billion to \$17.9 billion), as well as within the FY 1998 estimated range of improper payments at the 95 percent confidence level (\$7.8 billion to \$17.4 billion). The decrease may be due to sampling variability, which means that this year's results could differ simply because selecting different claims with different dollar values will inevitably produce a different estimate of improper payments.

The chart also demonstrates the trends in improper payments by the major categories of errors we have identified: (1) unsupported services, (2) medically unnecessary services, (3) coding errors, and (4) noncovered services and miscellaneous errors. As can be seen, unsupported and medically unnecessary services have been pervasive problems, accounting for more than 70 percent of the total improper payments over the 5 years.



<sup>1</sup>Does not add to total due to rounding.

Details on the various error categories, including the types of health care providers that accounted for the errors, are discussed below.

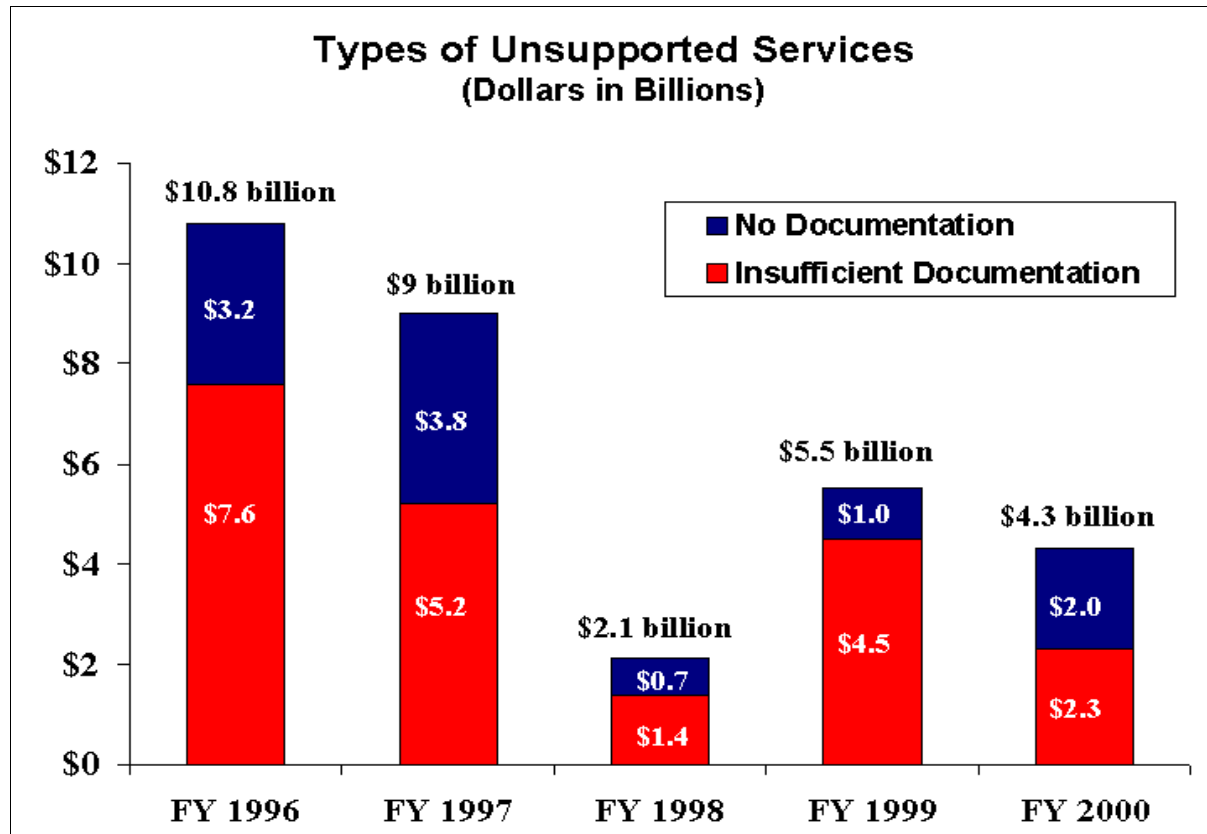
## Unsupported Services

Unsupported services represented the largest error category in 3 of the last 5 years. This year, these types of errors declined by 22 percent compared with the FY 1999 estimate — and by 60 percent compared with the FY 1996 estimate. However, they remain a significant problem, accounting for an estimated \$4.3 billion in improper payments.

Unsupported services represented the largest error category in 3 of the last 5 years.



The overall category of unsupported services includes two components: (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. As illustrated below, this year's errors in the "insufficient documentation" category fell by almost 50 percent, while those in the "no documentation" category doubled since FY 1999.



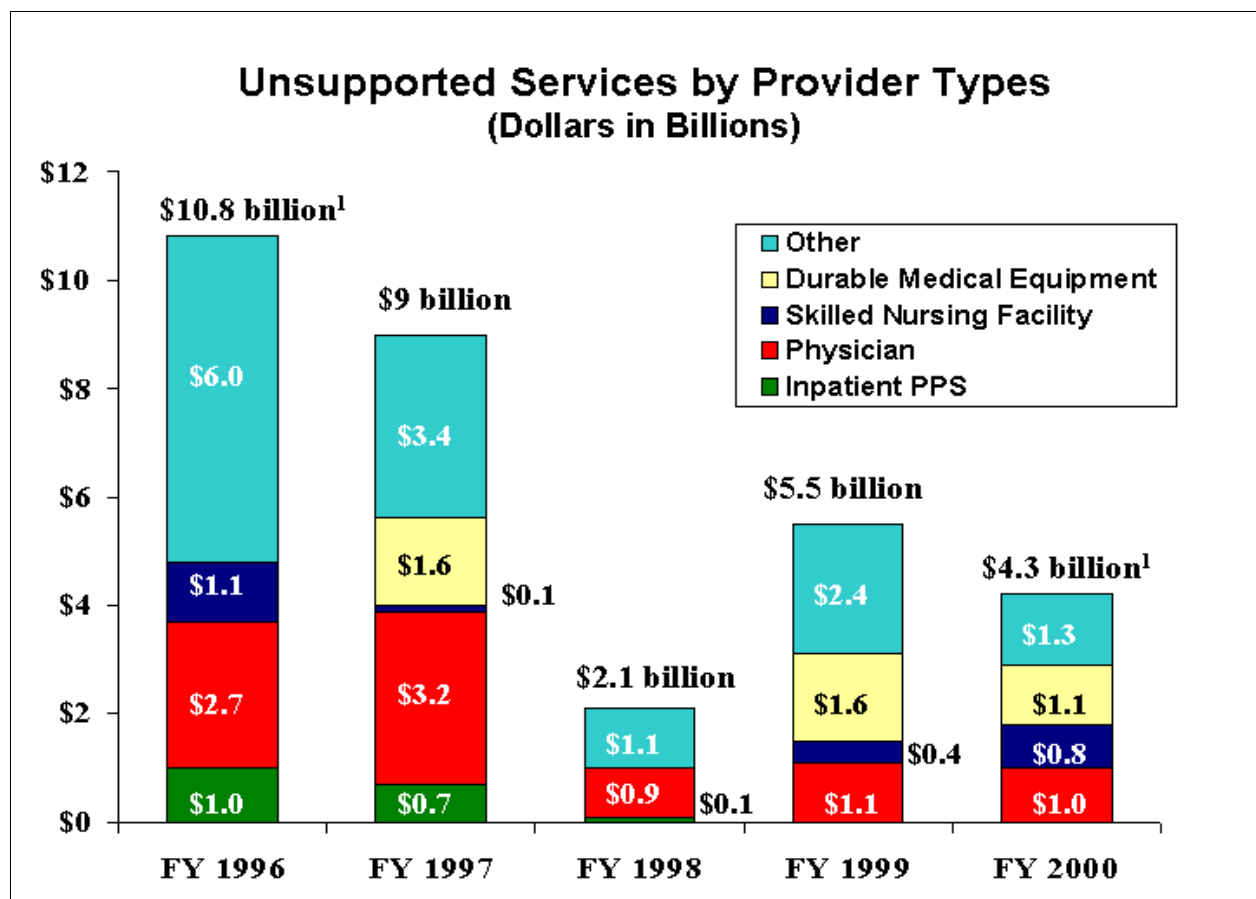
Like other insurers, Medicare makes payments based on a standard claim form. Medicare regulation, 42 CFR 482.24(c), specifically requires providers to maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed, and continued care. If sampled providers failed to provide documentation or submitted insufficient documentation, the contractors or OIG staff requested supporting medical records at least three times — and in most instances four or as many as five times — before determining that the payment was improper. Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries, the extent of services performed, or their medical necessity. It should be noted that HCFA upheld over 90 percent of the overpayments identified in our FYs 1996-1999 samples and recovered the bulk of them. (The exceptions concerned cases under investigation.)

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health, history (including past and present illnesses), examinations, tests,

treatments, and outcomes. Medical records chronologically document the care of the patient and are an important element contributing to high-quality care. The records assist in:

- C the evaluation and planning of the patient's immediate treatment and monitoring of the patient's health care over time by the physician and other health care professionals,
- C communication and continuity of care among physicians and other health care professionals involved in the patient's care, and
- C appropriate utilization review and quality-of-care evaluation.

As noted in the next chart, most provider types improved their compliance with Medicare documentation requirements this year.



<sup>1</sup>Does not add to total due to rounding.

Some examples of unsupported services follow:

- ☐ **Physician.** A physician was paid \$350 for 12 hospital visits for the evaluation and management of a patient. Because the physician did not provide any medical records to support five of these visits, \$175 was questioned.
- ☐ **Physician.** A physician was paid \$54 for the evaluation and management of a patient. After repeated attempts to obtain records supporting the claims, we received a letter from the provider stating that documentation for the visits could not be located. The medical reviewer denied the \$54 claim.
- ☐ **Physician.** A physician was paid \$48 for the evaluation and management of a hospital patient. After repeated attempts, we were told that no documentation could be located for the date of service. As a result, the claim was denied.
- ☐ **Home Health Agency.** A home health agency was paid \$76 for a physical therapy visit. However, there were no physician orders for the visit. Thus, the claim was denied.
- ☐ **Outpatient.** A hospital outpatient department was paid \$190 for radiology services. Despite repeated attempts, the medical reviewer was unable to obtain a signed physician order. Because Medicare requires that a signed physician order be included in the medical records for services rendered and billed, the entire claim was denied.
- ☐ **Outpatient.** A hospital was paid \$722 for outpatient radiation therapy services. The medical records contained no documentation to support these services. After the medical reviewer made numerous attempts to obtain such documentation, the provider responded that neither the radiology department nor the laboratory had found any records for the dates requested. As a result, the entire claim was denied.

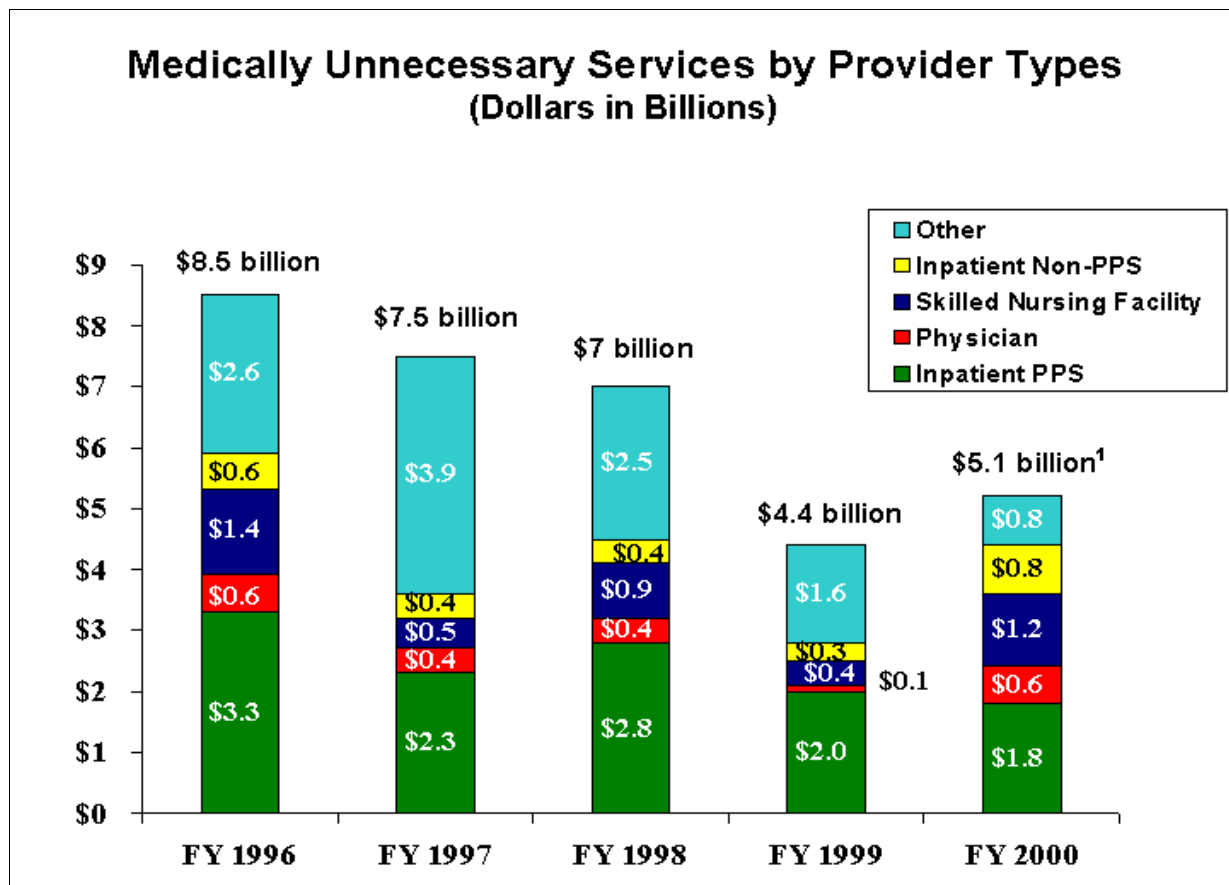
## Medically Unnecessary Services

This error category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the Medicare claims. Making such determinations has been an integral part of the Medicare contractors' quality control function since the program's inception, and OIG and HCFA have relied on their expertise to perform these services for many years.

Medically unnecessary services were a significant problem for the 5-year period.

Medically unnecessary services, the largest error category this year, amounted to \$5.1 billion. These errors represented a significant part of the overall error rate during the 5-year period:

37 percent of the improper payments for FY 1996, 37 percent for FY 1997, 56 percent for FY 1998, 33 percent for FY 1999, and 43 percent for FY 2000. As noted in the following chart, these types of errors in inpatient PPS claims have been consistently significant in all 5 years. In FY 2000, for example, 35 percent of the total \$5.1 billion was attributable to inpatient PPS claims.



<sup>1</sup>Does not add to total due to rounding.

Following are examples of services that were found not medically necessary:

- " ***Inpatient PPS.*** A PPS hospital was paid \$7,458 for an inpatient stay. This care was determined not medically necessary because the patient's diagnosis and condition during the stay did not justify the need for the admission. According to the medical reviewer, the patient could have been evaluated and treated in the emergency room, and any further treatment could have been provided in an outpatient setting.
- " ***Inpatient PPS.*** A PPS hospital was paid \$5,058 for an inpatient stay to treat a urinary track infection and dehydration requiring IV fluids. The PRO physician concluded that the patient's condition did not require hospital inpatient care and that the services could have been rendered in a less than acute setting.

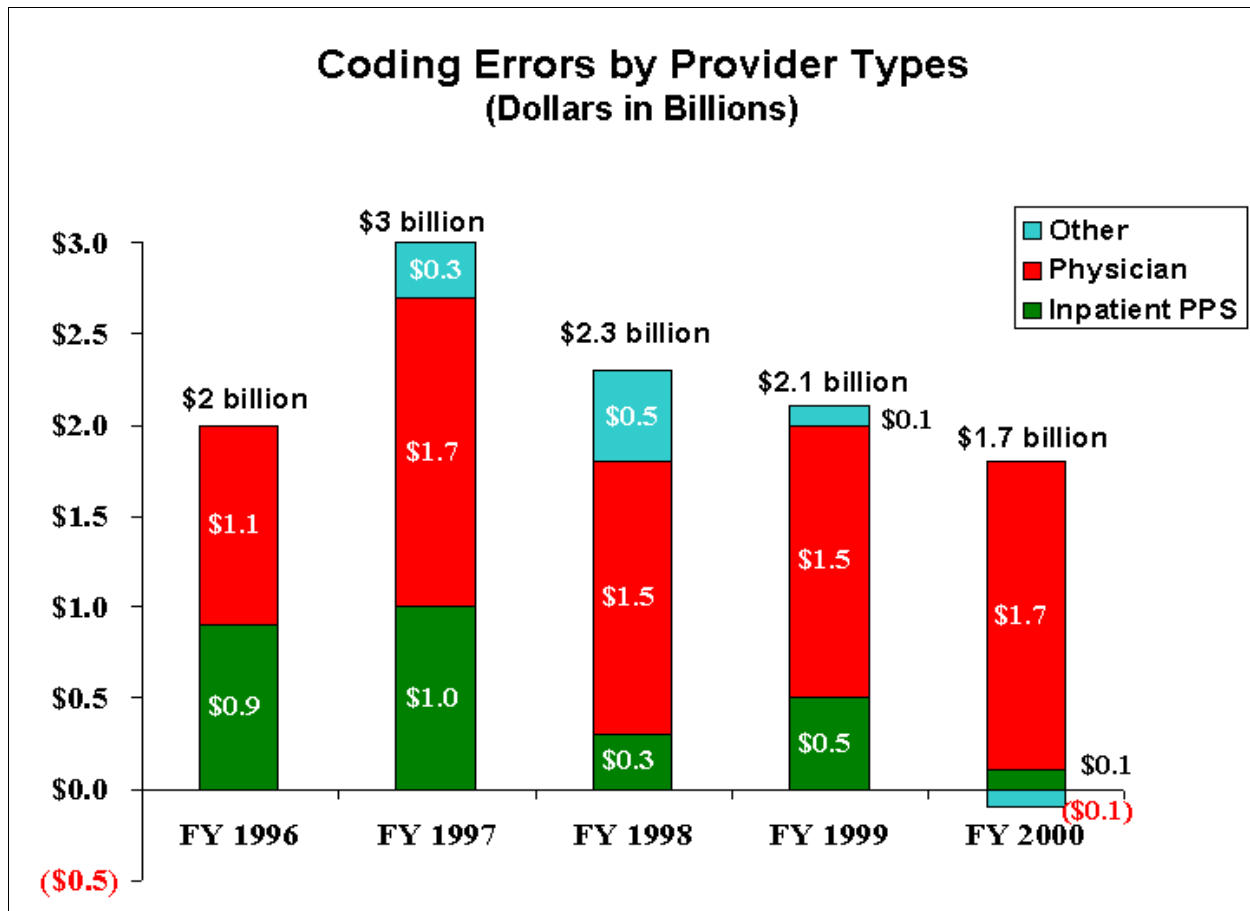
- ❑ **Inpatient PPS.** A PPS hospital was reimbursed \$3,011 for an inpatient stay. The beneficiary, whose medical history included many years of chronic back pain, was admitted with complaints of lower back pain. The patient was placed in an observation unit and admitted to acute care with the same orders as those in the observation setting. The medical reviewer determined that the care and services required for chronic back pain could have been provided in a less acute setting than inpatient admission.
- ❑ **Inpatient Non-PPS.** A rehabilitation hospital was paid \$18,125 for a 25-day stay. The beneficiary, with a history of chronic lung disease, had been admitted to an acute care hospital with a diagnosis of upper respiratory infection and was subsequently transferred to the rehabilitation hospital. The medical reviewers concluded that the beneficiary's condition was not severe enough to justify admission and that the therapy could have been performed on an outpatient basis.
- ❑ **Skilled Nursing Facility.** A skilled nursing facility was paid \$3,368 for inpatient rehabilitation services, including physical, occupational, speech, and recreational therapy. The medical reviewer determined that these services were not medically necessary because the patient had physical and mental limitations that prevented meaningful participation in therapy; instead, skilled nursing care and comfort measures should have been provided. As a result, the medical reviewer downcoded to a resource utilization group code that did not include therapies and denied \$1,010.
- ❑ **Physician.** A physician was paid \$3,305 for 40 hypnotherapy sessions with an Alzheimer's patient. The medical records stated that the patient was not attentive or cooperative during the initial mental status exam. Since the patient could not participate in that exam, the medical reviewer determined that hypnotherapy treatment was not medically necessary, reasonable, or appropriate for a 95-year-old Alzheimer's patient. The entire payment was denied.
- ❑ **Durable Medical Equipment.** A provider was paid \$205 for blood glucose home testing supplies. The beneficiary had received similar quantities of these supplies earlier in the year, which should have been sufficient, considering the usage prescribed by the physician. Since the documentation did not indicate the need for the excess supplies provided, the payment was denied.

## Coding Errors

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which were offset against identified upcoding situations.

Over the last 5 years, the net estimated dollar amount of coding errors has remained consistently in the \$2 billion to \$3 billion range.

Incorrect coding is the third highest error category this year, representing \$1.7 billion in improper payments (the net of upcoding and downcoding errors). As illustrated in the following chart, physician and inpatient PPS claims accounted for over 90 percent of the coding errors over the 5 years reviewed.



By letter dated June 1, 2000, the HCFA Administrator notified Medicare physicians that CPT codes 99214 and 99233 for evaluation and management services had accounted for a significant portion of the coding errors in our last two reviews. The Administrator noted that documentation for many of these services more appropriately supported CPT codes 99212 and 99231, respectively. The letter asked that providers, when billing for CPT code 99214, document at least two of the three key components: a detailed history, and/or a detailed examination, and/or medical decision-making of moderate complexity. This year's analysis has shown continued problems with these same procedure codes:

- C CPT code 99233, subsequent hospital care.* The physician should typically spend 35 minutes with the patient and perform at least two of these key procedures: a detailed interval patient history, a detailed examination, or medical decision-making of high complexity. Contractor medical reviews of 449 services in FY 2000 disclosed that 220, or 49 percent, were in error. Of the 220 errors, 200 were incorrectly coded and

subsequently downcoded to lower value procedure codes. Most of the remaining errors were for unsupported services. As noted in the chart below, our analysis for all 5 years has shown significant payment errors for this procedure code.

#### CPT Code 99233

Fiscal Year	Number of Services Reviewed	Number of Services Questioned	Percent of Services in Error
1996	217	115	53.0%
1997	416	128	30.8%
1998	457	114	25.0%
1999	187	102	54.6%
2000	449	220	49.0%

- CPT code 99214, office or other outpatient visit.** The physician should typically spend 25 minutes face-to-face with the patient and perform at least two of the following procedures: a detailed patient history, a detailed examination, or medical decision-making of moderate complexity. Contractor medical reviews of 191 services disclosed that 71 were in error, of which 64 were incorrectly coded. The remaining errors primarily related to unsupported services. Again, we have found consistent, significant errors for this code over the years.

#### CPT Code 99214

Fiscal Year	Number of Services Reviewed	Number of Services Questioned	Percent of Services in Error
1996	140	54	38.6%
1997	234	86	36.8%
1998	168	63	37.5%
1999	143	81	56.6%
2000	191	71	37.2%

In addition, although not highlighted in the Administrator's letter, we have noted a high incidence of error in CPT code 99232, subsequent hospital care, as illustrated in the next table. The physician should typically spend 25 minutes at bedside with the patient and should perform at least two of the following key procedures: an expanded problem-focused interval patient history, an expanded problem-focused examination, or medical decision-making of moderate complexity. For FY 2000, contractor medical reviews of 881 services disclosed that 270, or

31 percent, were in error. The majority, 231, were incorrectly coded, and the medical records consistently supported lower value procedure codes. Most of the remaining errors were for unsupported services.

**CPT Code 99232**

<b>Fiscal Year</b>	<b>Number of Services Reviewed</b>	<b>Number of Services Questioned</b>	<b>Percent of Services in Error</b>
<b>1996</b>	597	266	44.6%
<b>1997</b>	1,159	350	30.2%
<b>1998</b>	911	181	19.9%
<b>1999</b>	837	279	33.3%
<b>2000</b>	881	270	30.7%

Some examples of incorrect coding follow:

- ☐ **Physician.** A physician was paid \$83 for an office visit for the evaluation and management of a new beneficiary. This level of care requires a comprehensive history, a comprehensive examination, and medical decision-making of moderate complexity. The medical reviewers determined that medical records supported a level of care that was less complex and two levels of care lower than that billed. Therefore, \$42 was denied.
- ☐ **Physician.** A cardiologist was paid \$104 for an office visit for the evaluation and management of a new patient. This level of care requires a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. The medical review staff determined that the provider completed 19 of 23 critical elements required for a comprehensive examination by a specialist and that decision-making was only of a moderate nature. As a result, they concluded that the medical records actually supported a level of care that was less complex and two levels of care lower than that billed. Therefore, \$47 was denied.
- ☐ **Physician.** A physician was paid \$57 for inpatient hospital care for the evaluation and management of an established patient, which requires at least two of three components: a detailed interval history, a detailed examination, and medical decision-making of high complexity. According to the medical reviewer, the provider's documentation supported a lower procedure code. No medical history and decision-making were performed. Therefore, \$30 was denied.
- ☐ **Physician.** A physician was paid \$107 for initial hospital care for the evaluation and management of a patient, which requires three key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. According to the medical reviewer, the provider's documentation supported a lower



procedure code for a problem-focused history, an examination, and low-complexity medical decision-making. Thus, \$57 was denied.

- ❑ **Inpatient PPS.** A hospital was paid \$19,452 for providing a diagnostic related group (DRG) service to a patient admitted with a chronic inflammation of the membrane lining the abdominal wall. The principal diagnosis code was shown as another infection. The medical reviewers concluded that the diagnosis code should have been related to an infection due to a dialysis catheter. As a result, \$7,125 was denied.
- ❑ **Inpatient PPS.** A hospital was paid \$4,716 for a beneficiary who was admitted with a diagnosis described as occluded vertebral artery with infarction. The medical reviewers determined that the medical records did not support this diagnosis and that the principal diagnosis should have been alcohol abuse, which is a lower level diagnosis. As a result, \$3,544 was denied.

## Noncovered Services and Other Errors

Errors due to noncovered services have consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. According to the *Medicare Handbook*, the following services are not covered by Medicare Part B:

- most routine physical examinations and tests directly related to such examinations;
- eye and ear examinations to prescribe or to fit glasses or hearing aids;
- most prescription drugs;
- most routine foot care; and
- chiropractic services, unless the services are for the manipulation of the spine to correct a subluxation demonstrated by x-ray or by physical examination.

Following is an example of noncovered services identified during our review:

- ❑ **Physician.** A physician was paid \$71 for an office visit. The documentation stated that the visit was for a routine physical. There was no other documentation as to the reason for the office visit. Since Medicare does not pay for routine physicals, the payment was denied.

## CONCLUSIONS AND RECOMMENDATIONS

Based on our FY 2000 sample, we estimate that the Medicare fee-for-service payment error rate is 6.8 percent, or \$11.9 billion. This amount is about \$1.6 billion lower than that for

FY 1999 and the lowest since we began estimating improper Medicare payments. ***These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud.*** The reduction in improper payments since FY 1996, we believe, demonstrates HCFA's vigilance in monitoring the error rate and developing appropriate corrective action plans. In addition, significant contributions have been made by provider organizations, such as the American Medical Association and the American Hospital Association, in clarifying reimbursement rules and in impressing upon their membership the importance of fully documenting services. Lastly, fraud and abuse initiatives on the part of HCFA, the Congress, DOJ, and OIG have had a significant impact. All of these efforts have contributed to reducing the improper payment rate by half from FY 1996 to FY 2000.

It is commendable that the overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly. In this regard, over 90 percent of the Medicare fee-for-service payments for FYs 1998, 1999, and 2000 contained no errors. Thus, the majority of health care providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly.

While our 5-year analysis indicates progress in reducing improper payments, it also shows that unsupported and medically unnecessary services have been and continue to be pervasive problems. These two error categories accounted for over 70 percent of the total improper payments over the 5 years. The HCFA needs to sustain its efforts to maintain progress in reducing these improper payments. In particular, HCFA needs to continue working with providers to ensure that medical records support billed services. These records not only assist providers in evaluating and planning the patient's treatment but also ensure continuity of care in the event that another caregiver must assume responsibility for the patient's care. In addition, medical records help to ensure the correct and timely processing and payment of provider claims.

We recommend that HCFA:

- continue to direct that the Medicare contractors expand provider training to further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare for services provided;
- continue to highlight to Medicare providers specific procedure codes and DRGs having the highest incidence of error in our audits, as well as those codes and DRGs identified by Medicare contractor payment safeguard projects;
- direct its PROs to identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews;
- continue to refine Medicare regulations and guidelines to provide the best possible assurance that medical procedures and services are correctly coded and sufficiently documented;

- continue to encourage health care providers to adopt compliance plans that promote adherence to applicable Federal program requirements and laws; and
- ensure that contractors recover the improper payments identified in our review.

The HCFA officials agreed with our findings and recommendations, and their comments have been incorporated where appropriate.